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Trauma Reactivation Assessment and Treatment: Integrative Case Examples

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A framework for differentiating between subtypes of trauma reactivation is presented as a guide to client-treatment matching. Case examples are given to illustrate uncomplicated reactivation, complicated reactivation, and respective treatment implications. The rationale for utilizing a psychoeducational approach for treatment of uncomplicated reactivation and a psychodynamic approach for treatment of complicated reactivation is presented. Treatment implication for short-term disaster counseling services are discussed.

KEY WORDS: traumatic reactivation; PTSD treatment; integrative treatment model; disaster services.

INTRODUCTION

Numerous variables have been posited to explain the broad range in human adaptation to trauma. These variables include (a) the interrelationship between the trauma survivor's life history factors, pretrauma characteristics, premorbid adjustment, and developmental history (Green *et al.*, 1985; Helzer *et al.*, 1979; Solomon *et al.*, 1987; Sudak *et al.* 1984); (b) the survivor's stage of ego development at the point of trauma (Wilson, 1978, 1980); (c) the role of support systems (Atkeson *et al.*, 1982; Green *et al.* 1985; McCahill *et al.*, 1979); (d) the severity, frequency, and duration of the stressor(s) (Keane, 1985; Keane *et al.*, 1985; Kilpatrick *et al.*, 1985; Kulka *et al.*, 1990; Wilson *et al.*, 1985); (e) the meaning of the event (Lifton, 1967); and (f) the complex interaction between the individual, the stressor, and the traumatic and post-traumatic environments (Catherall, 1989; Green

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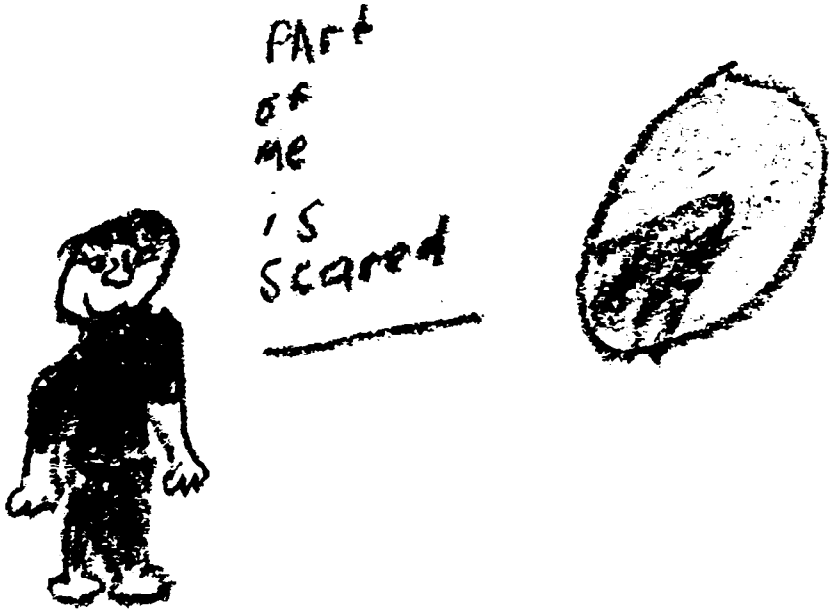

Fig. 1. Child's drawing illustrating positive symptoms.

et al., 1985; Lazarus and Folkman, 1984; Wilson *et al.,* 1985). In addition, clinicians have reported that acutely traumatized individuals with a history of previous traumatic experiences may be especially prone to experience adaptation problems, including the reactivation of previous traumatic symptoms (Lindemann, 1944; Solomon *et al.,* 1987; 1990). In these individuals, recent trauma serves to reactivate adjustment problems that are associated with the earlier trauma.

Solomon *et al.* (1987) propose a reactivation model in which two categories of reactivated trauma are outlined. The first, referred to as *uncomplicated reactivation,* is characterized by individuals who return to their level of premorbid functioning, i.e., they become symptom-free. These individuals, however, remain particularly vulnerable to the reactivation of traumatic symptoms when exposed to stimuli that are directly reminiscent of the original trauma. In a second category called *complicated reactivation,* individuals develop a more generalized sensitivity and vulnerability to stressors and stimuli not directly related to the original trauma.

Parallel constructs proposed by Catherall (1989) and Keane (1989) provide valuable references for the treatment of uncomplicated and complicated trauma reactivation. In these heuristics, two central clinical issues

Fig. 2. Child's drawing illustrating negative symptoms.

are conceptualized: conflicts in ego integration (referred to by Catherall as primary trauma); and the loss of self-cohesion (secondary trauma). In primary trauma, "positive" symptoms[2] related to sensory reminders, intense affective states, intrusive thoughts, and psychic numbing, are produced. The victim is intact characterologically, but cannot assimilate or tolerate the

[2]Catherall's use of primary and secondary traumatization is not consistent with conventional use of these terms. Primary traumatization is generally understood to refer to a victim's response to trauma while secondary traumatization refers to the impact of a victim's traumatization on significant others. Keane (1989) posited a dichotomization of post-traumatic symptoms similar to Catherall's, labeling them "positive" and "negative" symptoms respectively. In an effort to avoid confusion with the general understanding of primary and secondary trauma, the paper will use Keane's lexicon.

feelings associated with the trauma. This symptom picture is illustrated in an eight year old child's drawing of his 1989 Loma Prieta earthquake experience (see Fig. 1). In this figure, the child is seen smiling toward the viewer and appearing to be generally intact. He has drawn a circle graphically showing that only part of this sphere is different and has stated that only *part of himself is scared.*

"Negative" symptoms, produced in secondary trauma, are characterized by a misalignment/dysynchrony between the victim and his or her social environment. Here, the psychological impact is more severe, and results in social withdrawal, feelings of mistrust and alienation, identity disturbance, and interpersonal difficulties that amount to a "disorder of the self." A second 8-year-old child's drawing of her Loma Prieta earthquake experience is presented to illustrate negative symptoms (see Fig. 2). In this child's drawing, she appears terrified and her eyes are averted from the viewer. She has placed herself inside a space with no exit or entry. In effect, the impact of the event has resulted in a "walling-off" or social withdrawal from the environment/others and from something outside of view.

Catherall suggested that each type of traumatization requires distinct treatment. For positive symptoms, the major therapeutic task involves facilitating the individual's (ego) capacity for conscious assimilation of trauma information that is dramatically discrepant from the individual's beliefs, assumptions, and world view. This process involves a thorough self-examination with regard to the traumatic material and its implications. The therapeutic task in treating negative symptoms requires facilitating the individual's capacity to reconstitute a sense of self through a process of empathic engagement.

The subtypes of traumatization proposed by Catherall (1989) and Keane (1989) match the subtypes delineated by Solomon *et al.* (1987). Positive symptoms are dominant in an uncomplicated reactivation, whereas, negative symptoms are dominant in a complicated reactivation. In cases of uncomplicated reactivation (that is positive symptoms), a psychoeducational approach is appropriate. The alternation of active listening and ventilation techniques with didactic information about stress response syndromes is useful to assist the victim's process of assimilating the trauma experience (see Table I). The clinician seeks to understand the context of the reactivation in view of the victim's psychosocial history including significant life events, significant stressors prior to the recent traumatic event, coping strategies successfully employed toward adaptation to the original trauma, circumstances of the traumatic events, the victim's behavioral, emotional, and cognitive response to the events, and the effect on the victim's family, job, and social relationships. Techniques are used to facilitate cognitive restructuring of the victim's cognitive distortion, and often include the use

Table I. Psychoeducational Treatment for Uncomplicated Reactivation

A.	Alternating examination of traumatic event and victim's psychosocial history
B.	Examination of victim's emotional response to traumatic events and their aftermath
C.	Examination of victim's perception of change
D.	Examination of repercussions on job, social life, and life patterns
E.	Examination of how victim adapted to previous trauma(s)
F.	Examination of how victim could behave differently should similar event occur
G.	Facilitation of cognitive restructuring and positive meaning of events
H.	Information-giving about stress response syndromes
I.	Use of active listening and ventilation techniques

of family counseling and efforts to mobilize the client's support system. Exposure based treatments utilizing systematic desensitization and implosive therapy (Keane *et al.*, 1989; Fairbank and Keane, 1982; Keane and Kaloupeck, 1982) and psychopharmacological treatment also work well (Friedman, 1990; Keane *et al.*, 1992).

In cases of complicated reactivation (that is negative symptoms), a psychodynamic approach is appropriate. Although the clinician must similarly seek to understand the reactivation in context of the victim's psychosocial history, the approach must emphasize *process* rather than *content* to facilitate the victim's process of self reconstitution. Waldinger's (1987) outline of treatment tenets for borderline personality disorders may be applied, since both individuals with borderline personality and this form of posttraumatic stress disorder exhibit a loss of self-cohesion. These tenets have been incorporated into the proposed psychodynamic treatment for complicated reactivation (see Table II). This approach attempts to provide a holding environment that facilitates the reconstitution of the self. A stable treatment framework strives to tolerate the victim's negative symptoms and provides empathic support. The establishment of regular appointment times, prompt beginning and ending session times, and clear payment ex-

Table II. Psychodynamic Treatment for Complicated Reactivation

A.	Emphasis on process and active empathic listening rather than content
B.	Provision of a holding environment to facilitate victim's self-cohesion
C.	Alternating examination of victim's psychosocial history and traumtic event(s)
D.	Examination of relationship between victim's behavior and feelings, initially focusing interpretations on present
E.	Facilitation of differentiation between present stimuli and past threats
F.	Facilitation of cognitive restructuring and positive meaning of events
G.	Teaching problem solving and stress management skills as they apply to current problems
H.	Providing information regarding stress-response syndromes
I.	Examination of how victim could behave differently should similar event occur

pectations, are ancillary to the clinician representing a stable object offering consistent support and care. The clinician attempts to facilitate the victim's understanding of the consequences of behavior. If and when therapeutic trust has been established, the victim may be helped to differentiate between past threats and present stimuli. At this point, the victim may be encouraged to find a positive meaning to his/her life events. Lastly, the clinician attempts to enhance the problem solving and stress management skills of the survivor.

To illustrate the assessment and treatment of uncomplicated and complicated reactivations, two case studies are presented. In the first case, a 64-year-old German World War II nurse who survived the 1943 incendiary bombing of Hamburg and the 1989 Loma Prieta earthquake is given to illustrate an uncomplicated reactivation and treatment. In the second example, the case of a 50-year-old woman who had been a victim of childhood sexual molestation, a witness to the accidental death of her child and husband, and retraumatized by the earthquake is provided to illustrate a complicated reactivation and treatment considerations.

CASE EXAMPLE OF UNCOMPLICATED REACTIVATION

UR was a 17-year-old nurse in 1943, when British bombers launched the bombing of Hamburg, killing more than 100,000 people, leaving 750,000 homeless, and destroying 6000 square acres of homes, factories, and office buildings. The night the air raid began UR huddled in the basement of the nursing barracks, along with 62 other nurses, including her older sister and a nursing supervisor. As terror and confusion broke out, UR, not the supervisor, directed the nurses to safety. The entire hospital was destroyed and Hamburg itself was ablaze and unsafe. UR led her sister and another woman to their hometown, a 70-mile journey which included repeated exposure to aerial shootings, devastation, and the horror of war.

During the war and for nearly ten years after, UR claims not to have suffered from nightmares. She does, however, describe having developed a startle response, intrusive thoughts, and a growing fear of entrapment. The onset of nightmares occurred when she and her husband moved to the United States in 1956. The experience of being in a new country, not knowing English, having little money and no friends nor support, apparently produced considerable stress and the nightmares about Hamburg began. It wasn't until 4 years later, upon the birth of her first child, that the nightmares reportedly stopped.

When the Loma Prieta earthquake hit California, in October 1989, UR was just opening the front door to her home, with her daughter and

a friend at arms length behind her. Inside, her husband was uninjured but visibly shaken. She reports that during the quake she did not feel that her life was threatened. UR began to have crying spells and on or about the fifth day following the quake, she began to experience nightmares and intrusive thoughts specific to the incident in Hamburg. Thirty days after the quake, UR requested counseling services provided by the National Center for PTSD, Clinical Laboratory and Education Division's (NC-PTSD) earthquake response project, having been referred by someone she met at a county mental health "drop-in earthquake recovery group." She had attended three such groups, but concluded that her experience, which included reactivated WWII memories, would not be understood by other group participants. She presented as an engaging, self-assured, and value-driven adult who, at the same time, was slightly anxious, quick to tear, emotionally vulnerable, and distressed by her emotional state. Her chief complaint was that of the nightmares and intrusive recollections about the Hamburg bombing.

In this case example, the earthquake appears to have precipitated an uncomplicated reactivated trauma. Earthquake stimuli reminiscent of the original trauma (i.e., violent shaking, collapsing buildings, unpredictable and uncontrollable aftershocks) precipitated positive symptoms related to sensory reminders—intense emotions, intrusive thoughts, and nightmares. Indications of a complicated reactivated trauma (generalized sensitivity and negative symptoms) were not evident. The client expressed a cohesive self and her social environment and relationships were characterized by close friendships and purposeful activities rather than alienation and withdrawal.

This assessment suggested that a psychoeducational approach would be useful to resolve the positive symptoms and the conflicts of ego integration. The therapeutic task of assimilation was twofold: (a) helping the client to understand herself through the utilization of information, particularly how her experience of the earthquake reactivated painful memories and nightmares of the war; and (b) facilitating and modeling tolerance for the client's emotional ventilation to encourage assimilation of the traumatic experience.

An account of her early memories of childhood and adolescence was first obtained. The pre-trauma review served to encourage the client's sense of control, in addition to providing valuable information. A review of the war took into account moment-to-moment events during the bombing and the days afterward. This review was extended to include an account of her life after the war up to the events of the present. When appropriate, information regarding stress response syndromes would be interjected. The effect of orchestrating information-giving with encouraging emotional ventilation appeared to buttress the client's tolerance for increasing amounts

of traumatic-linked affect and its assimilation. After two weeks and three sessions, the account was "finished." She reported much relief of the positive PTSD symptoms and that the nightmares and intrusive recollections had stopped. At 3- and 9-month follow-up periods, the client remained free of sleep disturbance and nightmares.

CASE EXAMPLE OF COMPLICATED REACTIVATION

As a child, CR was the victim of repeated sexual molestation. Later, as a new mother in her twenties, her husband lost control of their car and her infant daughter, sitting on her lap, was killed; her husband was also killed. In both the cases of UR and CR, the violent shaking caused by the earthquake, and the unpredictability of its aftershocks reactivated traumatic symptoms. However, unlike UR, the quake exacerbated CR's chronic feelings of anxiety, vulnerability, and irritability and disturbed her tenuous sense of self, leading her to explicitly question her identity.

After participating in an employer sponsored earthquake debriefing group, CR was referred by the debriefing facilitator to the county's disaster counseling project for individual treatment. After the fourth individual session, the disaster project requested a case consultation from the NC-PTSD earthquake response project to discuss assessment and treatment issues.

At the time of her presentation for treatment, CR described sleep disturbance, intrusive thoughts, and a loss of interest in activities which appeared to be precipitated by the earthquake. Her description of identity disturbance and intense, unstable relationships was consistent with the negative symptoms of traumatization. In addition, the exacerbation of residual negative symptoms from earlier traumas suggested a sensitivity to stimuli not directly related to the previous traumatic events. She appeared to be hypersensitive to criticism, to struggle for control during interpersonal interactions, maintain an inordinate distrust of authority, and expressed that she often felt victimized, treated unfairly, and misunderstood. She believed she was entitled to special treatment that included services in her home on the weekends and evenings.

This example of a complicated reactivation illustrates a notably different response syndrome than the individual with an uncomplicated reactivation. Tragically, in CR's case the psychological sequelae of the earlier traumas resulted in a severe impairment of her sense of self and of her social functioning. In addition to symptoms of PTSD, CR also exhibited the Axis II features of a borderline personality disorder (American Psychiatric Association, 1987). The etiology of this personality disorder is consistent with her history of repeated childhood sexual molestation and the

issues of mistrust and ambiguous boundaries inherent in this form of victimization. Features of borderline personality disorder would have been exacerbated by the death of her daughter and husband, as CR suddenly and unpredictably lost her identity as a wife and mother. In this example, posttraumatic stress disorder and borderline personality disorder are concurrent psychiatric diagnoses.

In such cases, the therapeutic relationship is the primary instrument for change. In light of her apparent comorbid personality disorder, resistance to treatment, and fragile psychological makeup, CR was not a good candidate for time-limited psychoeducational therapy, typically used in disaster counseling, or exposure based therapy (Litz *et al.,* 1990). A victim predominantly suffering from a complicated reactivation is more appropriately referred to long-term therapy. Subsequently, a referral, with these aims in mind, was made by the disaster project as a result of the consult. Regrettably, CR dropped out of treatment after her intake session with the "long-term" therapist.

DISCUSSION

Differentiating between types of traumatic reactivations may serve as critical determinants of the type and sequence of treatment interventions. Similar to a heuristic recently described by Terr (1991) regarding type II childhood traumas, it is imperative that the assessment of traumatic reactivation include a thorough psychosocial history to determine the form of reactivations described herein. A psychoeducational approach appears appropriate in cases of uncomplicated reactivation, but less appropriate in cases of complicated reactivation. In cases of uncomplicated reactivation the clinical effort is directed toward facilitating client self-understanding. Support for emotional ventilation and didactic information are given to encourage the integration and assimilation of the traumatic reactivation.

In cases of complicated reactivation, the clinical effort is directed toward helping the victim to feel understood. Efforts to promote self understanding or active problem solving are likely to meet intense resistance in the form of mistrust, hostility, and complaints about not being understood. Such cases require an emphasis on process rather than content. Clients who are assessed as having a complicated trauma reactivation, are more appropriately referred to long-term treatment by disaster service clinicians. In long term-treatment, the client exhibiting a decrease in negative symptoms can examine constructive ways to view the consequences of the traumas (i.e., the events may serve to clarify life values and priorities). This

positive reframe is adopted in the context of the victim's learning problem solving skills for current difficulties and skills for stress management.

A note of caution is in order with regard to the case illustrations. Social theorists and socially-oriented clinicians have examined factors other than those characterized by psychodynamic processes, in an attempt to further understand how individuals respond to undesirable life events (Moos, 1988; Silver and Wortman, 1980). These factors may explain much of the therapeutic success or lack thereof in this report. Indeed, in the case of UC, a broad range of coping skills was employed, suggesting her use of powerful adaptation mechanisms beyond those enhanced by the therapy.

This paper provides an illustration of the clinical integration of trauma reactivation and treatment models. Hopefully, the framework for differentiating forms of trauma reactivation and symptoms will spur research and facilitate client-treatment matching.

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